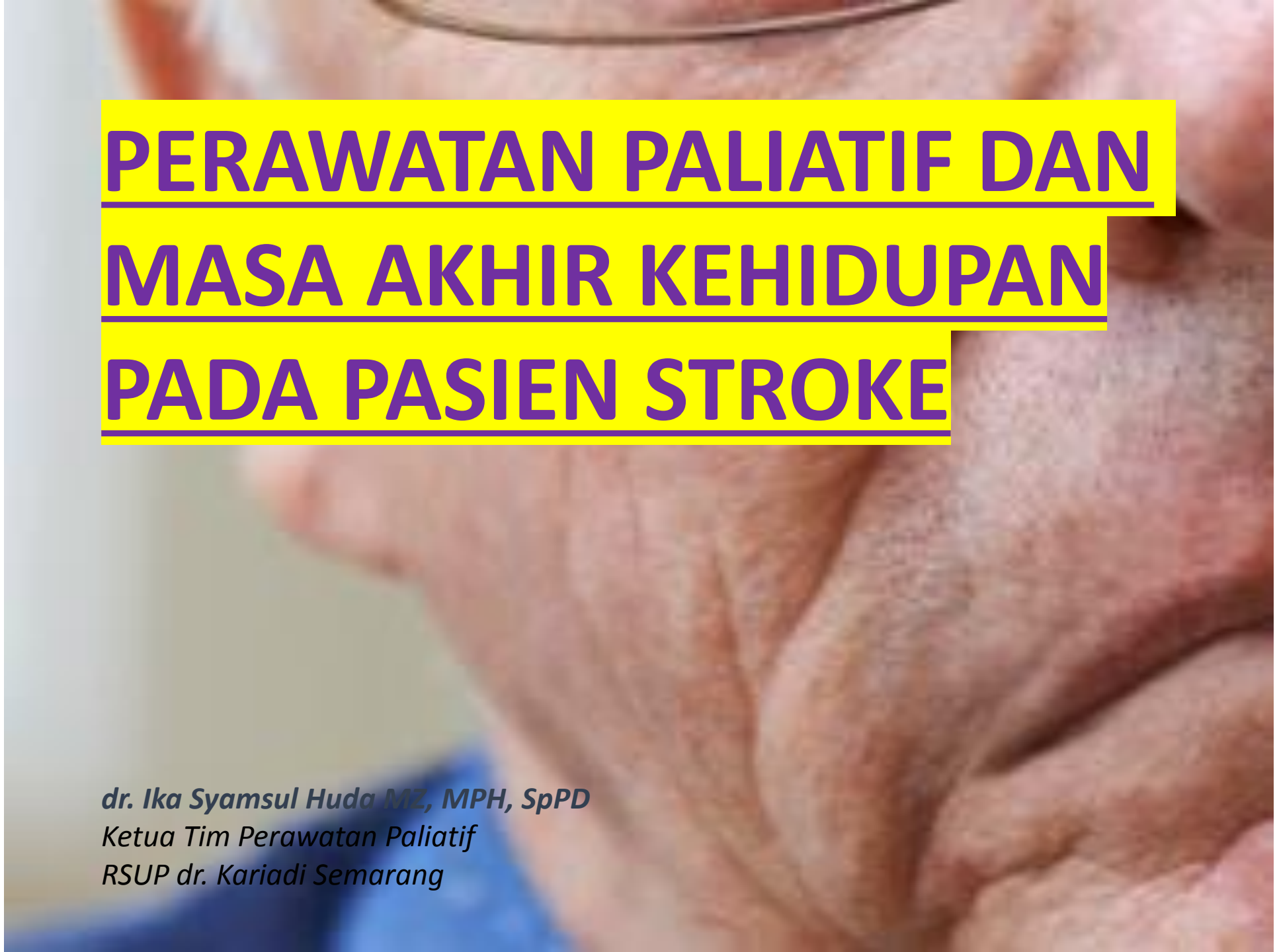


PERAWATAN PALIATIF DAN MASA AKHIR KEHIDUPAN PADA PASIEN STROKE

dr. Ika Syamsul Huda MZ, MPH, SpPD
Ketua Tim Perawatan Paliatif
RSUP dr. Kariadi Semarang

Butterflies

are known as a symbol of transformation, hope, life, and spirit.

https://www.facebook.com/NHPCO/posts/butterflies-are-known-as-a-symbol-of-transformation-hope-life-and-spirit-hospice/10155750819413907/

WHO Definition of Palliative Care

Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.

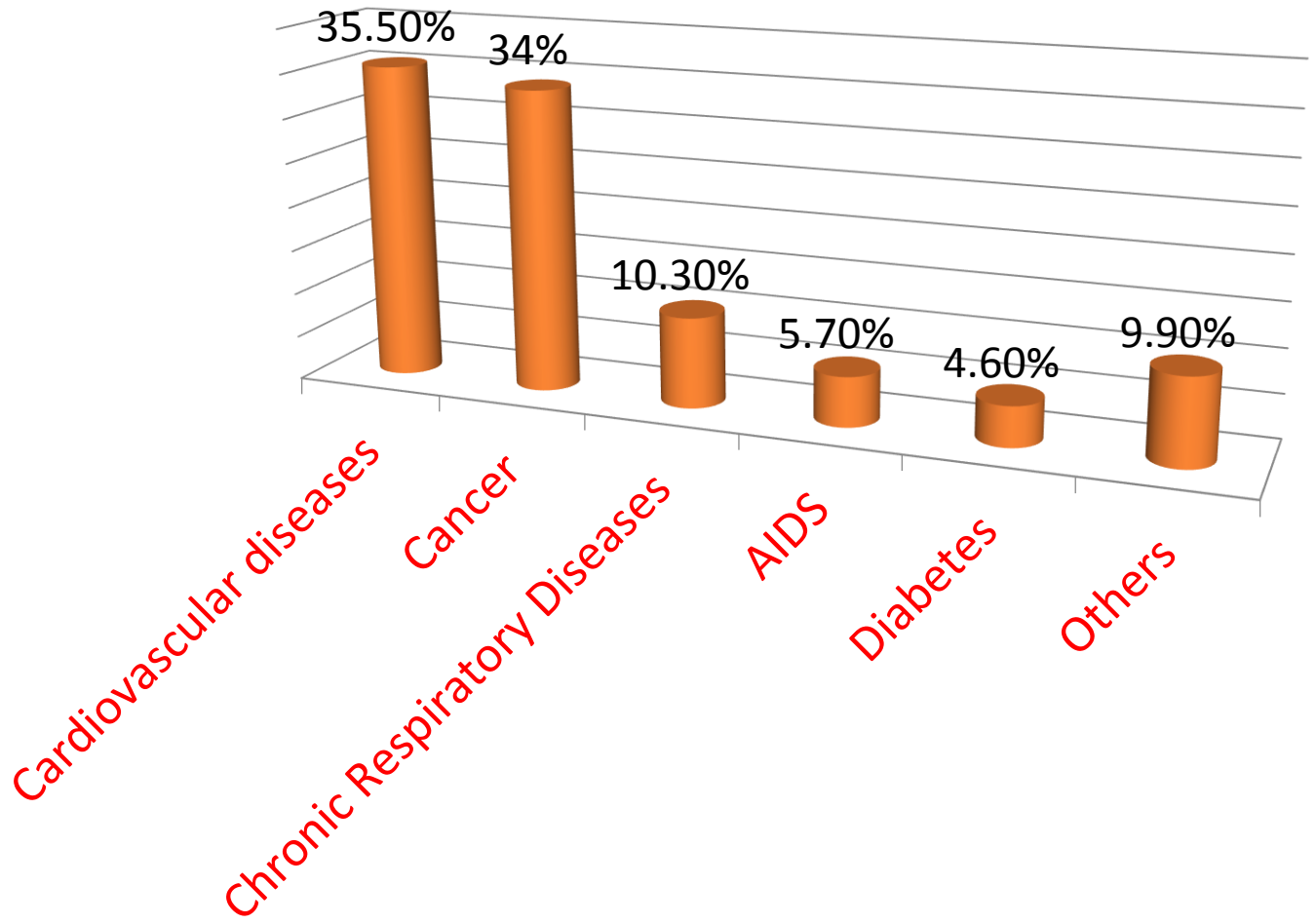
http://www.who.int/cancer/palliative/definition/en/

Quality of Life (QoL)

- **Kualitas hidup (QoL)** didefinisikan sebagai persepsi individu tentang posisi mereka dalam kehidupan dalam konteks budaya dan sistem nilai di mana mereka hidup dan dalam kaitannya dengan tujuan, harapan, standar, dan kekhawatiran mereka.

- Ini adalah konsep luas yang dipengaruhi secara kompleks oleh kesehatan fisik seseorang, keadaan psikologis, tingkat kemandirian, hubungan sosial, dan hubungan mereka dengan ciri-ciri menonjol dari lingkungan mereka.

PALLIATIVE CARE IS REQUIRED FOR A WIDE RANGE OF DISEASES



http://www.who.int/en/news-room/fact-sheets/detail/palliative-care

Dame Mary Cicely Saunders

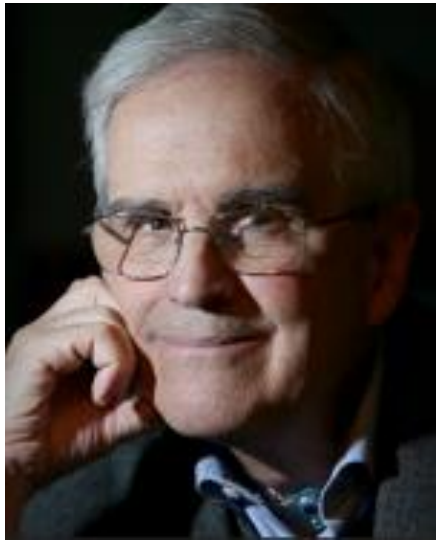
TOTAL PAIN

Total pain recognises pain as being ***physical, psychological, social and spiritual.***

INTERDISCIPLINARY
TEAMWORK IN PALLIATIVE CARE

- Hospice care movement

Dame Mary Cicely Saunders
(22 Juni 1918 - 14 Juli 2005)



dr. Balfour Mount
Born 14 April 1939
Urological surgeon
Father of Canada's palliative care movement

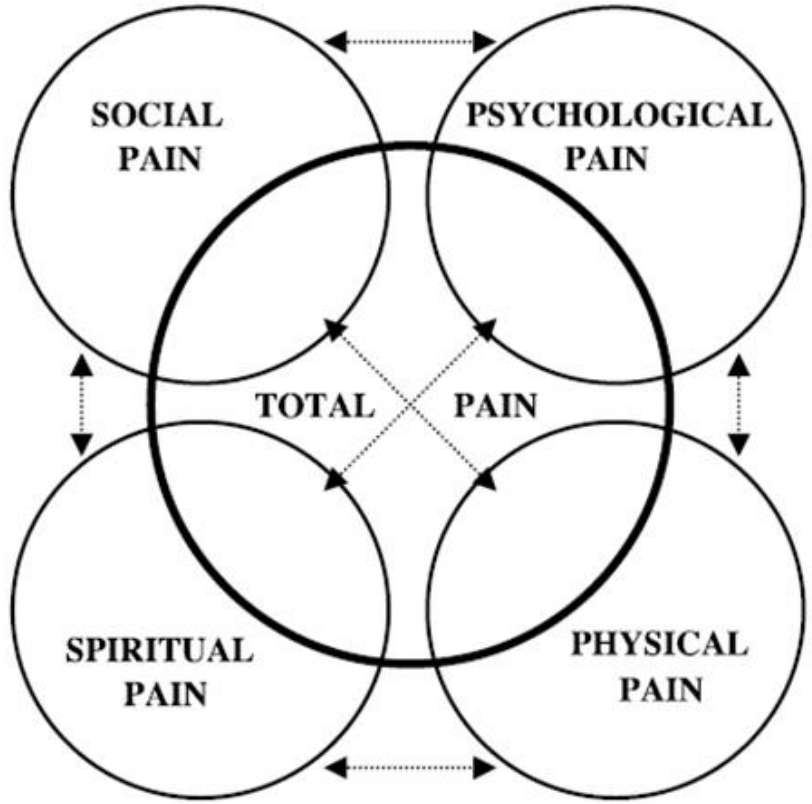
PALLIATIVE

Palliare (Bahasa Latin)

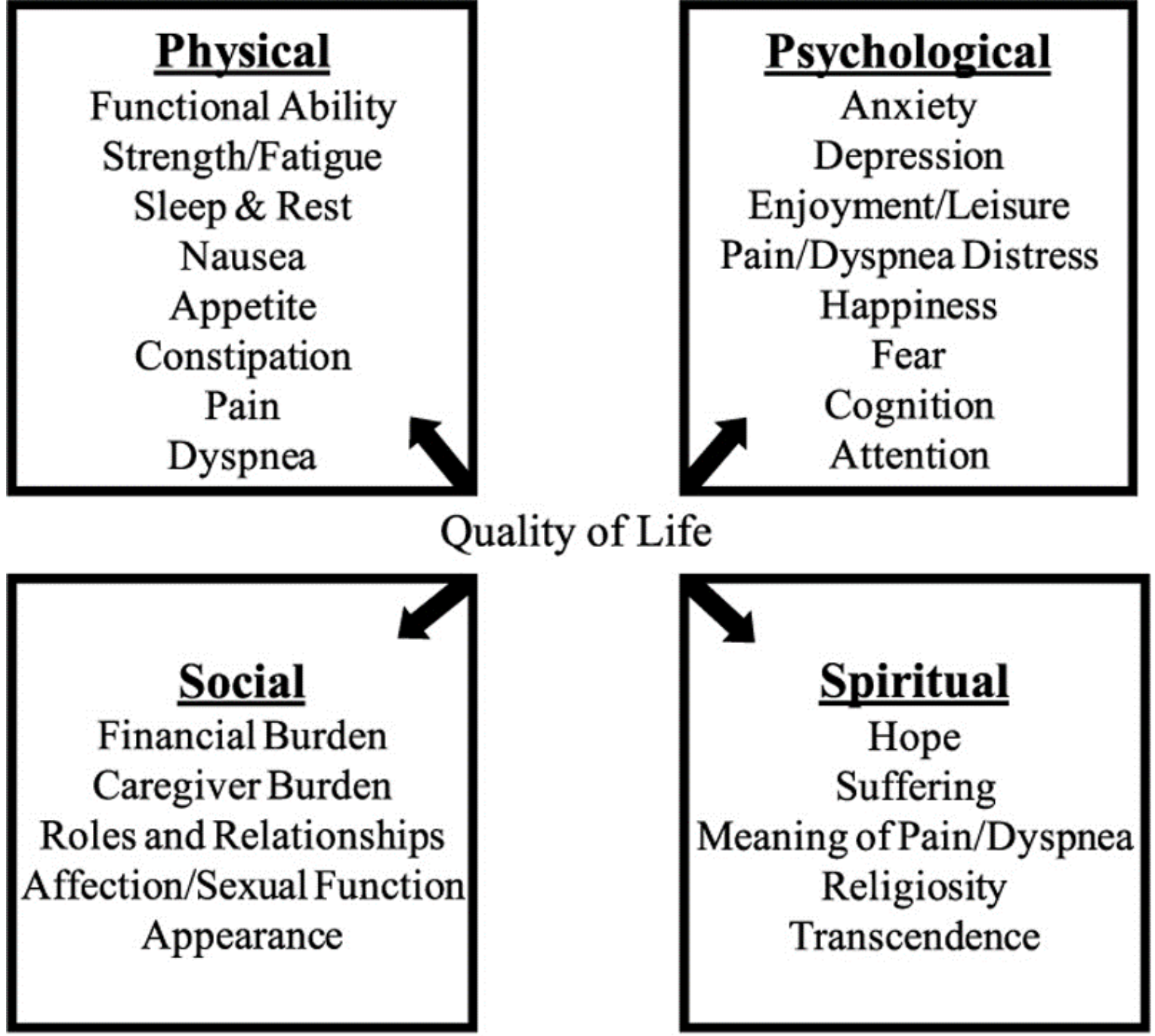
= to cloak, cover

jubah, mantel

TOTAL PAIN



The total pain experience: an interactive model.



Adapted from Ferrell et al., 1991

Palliative care can focus on:

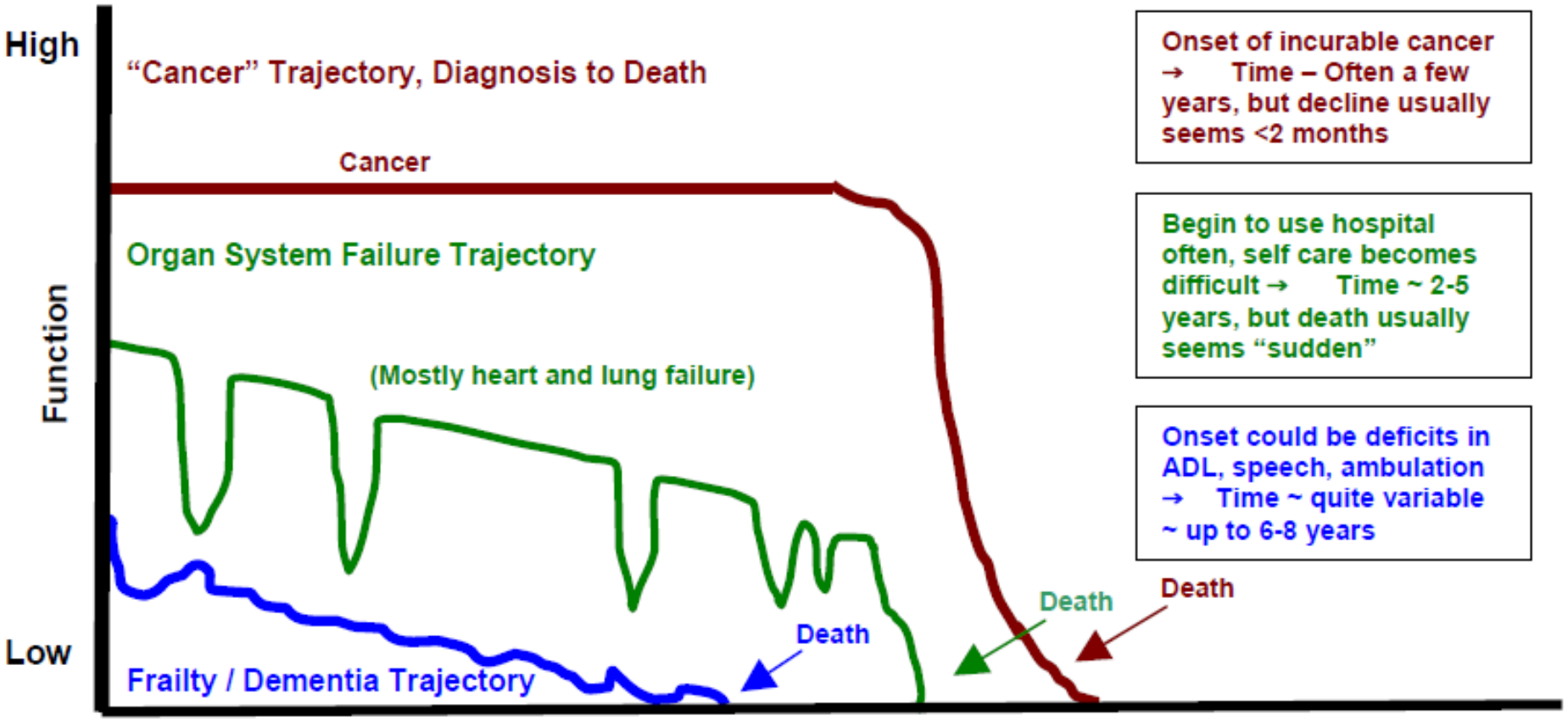
- controlling symptoms
- independence
- emotional, spiritual and cultural wellbeing
- planning for the future
- caring for patient's family and carers

https://www.health.qld.gov.au/news-events/news/what-is-palliative-care-Queensland

What ISN’T Palliative Care

- *Palliative Care IS NOT only for actively/imminently dying patients*
- *Palliative Care IS NOT doing nothing*
- *Palliative is never futile*
- *Palliative Care DOES NOT start when curative treatment stops; it is simultaneous along the continuum of care*
- *Palliative Care DOES NOT convince patients to stop treatment*
- *Palliative Care DOES NOT take the place of care by the patient’s personal physician*
- *Palliative Care IS NOT Hospice Care*

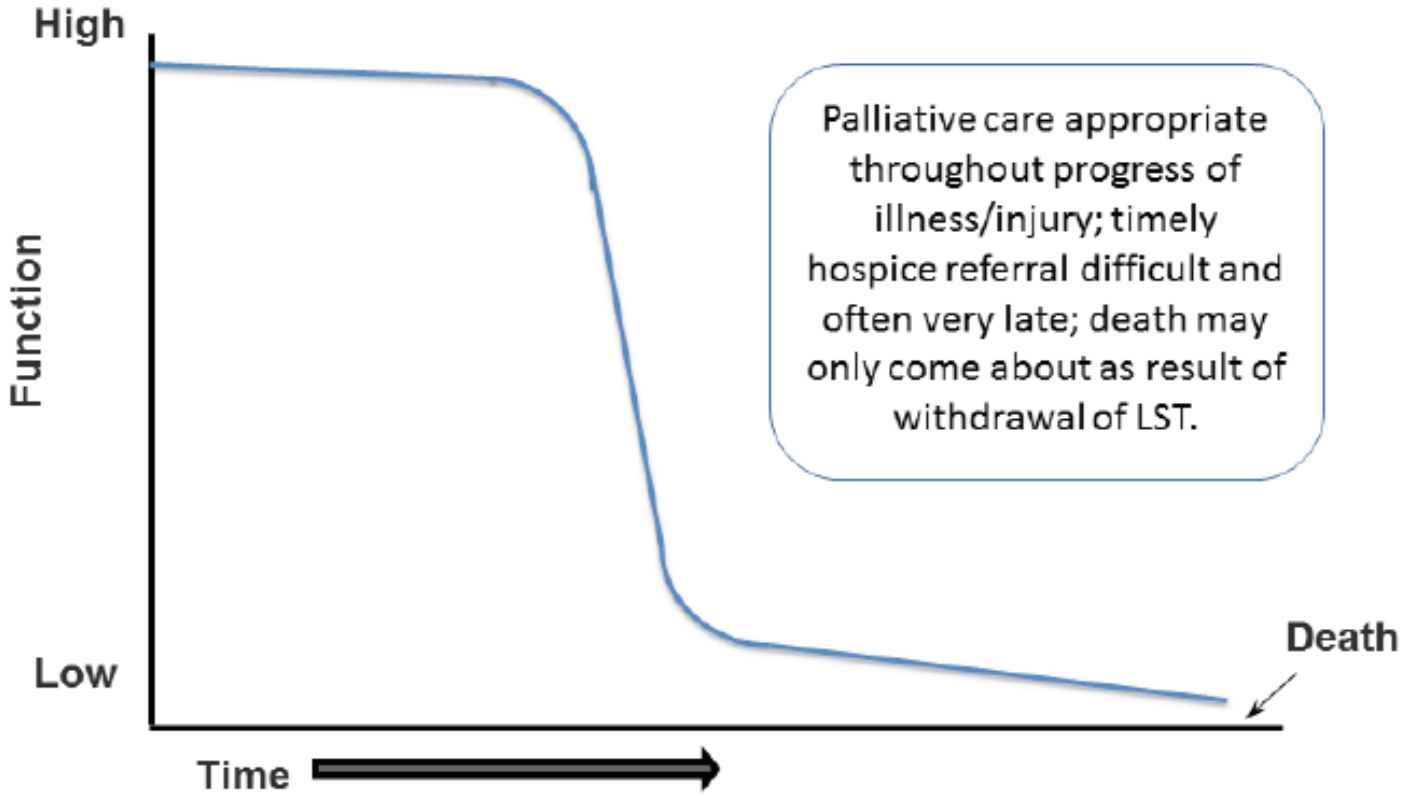
LINTASAN SAKIT



ILLNESS TRAJECTORY

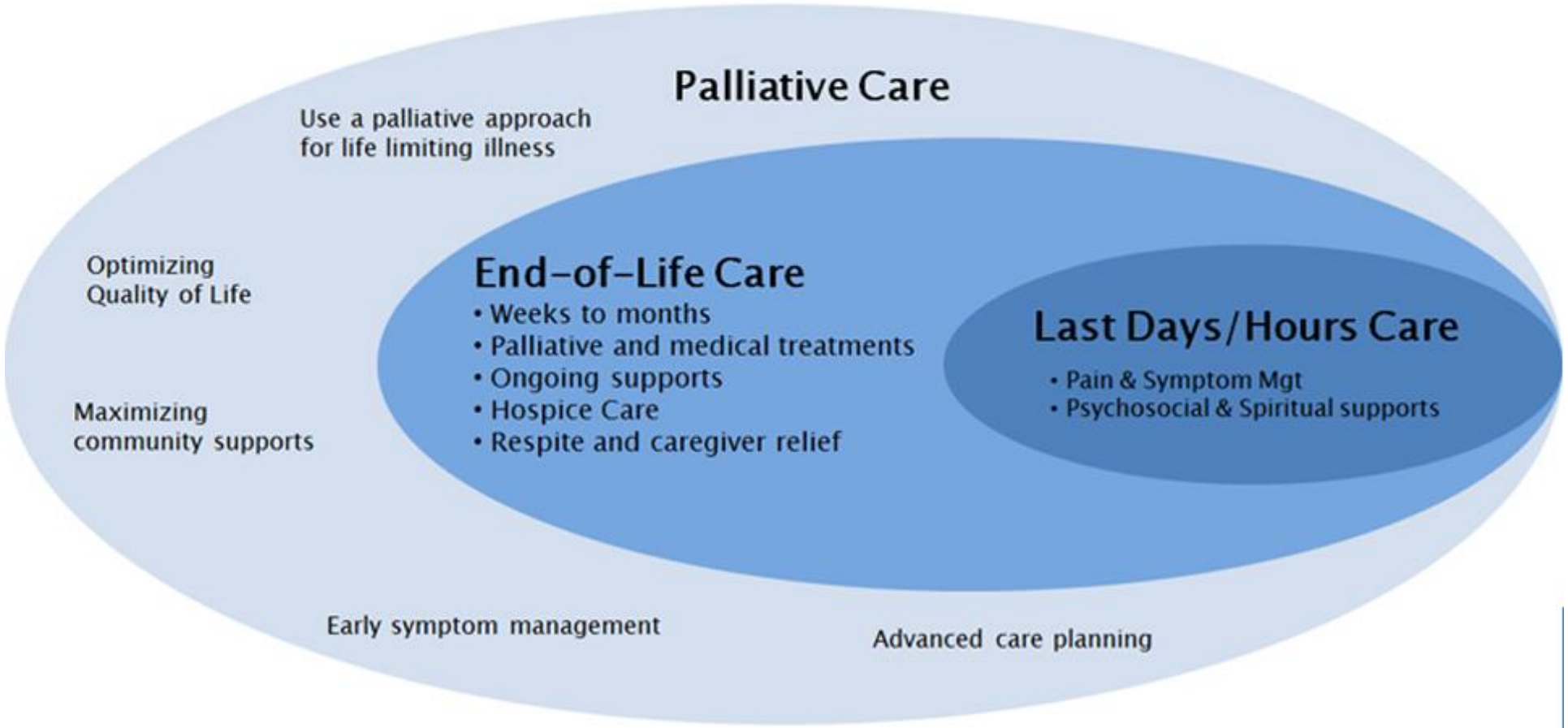
Department of Health, Western Australia. Palliative Care Model of Care. Perth: WA Cancer & Palliative Care Network, Department of Health, Western Australian; 2008.

Catastrophic Event (Stroke, TBI, Hip Fracture in Elderly)



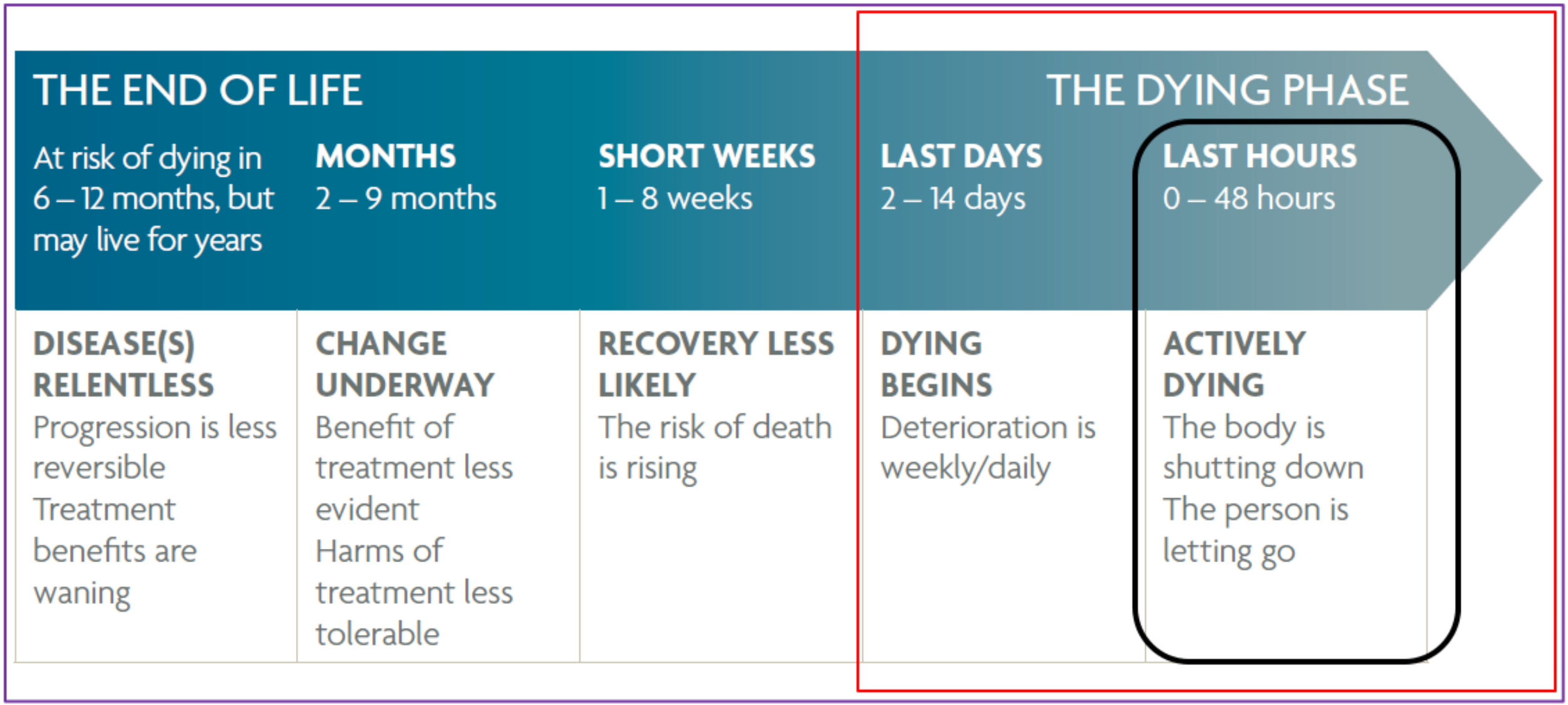
Catastrophic Event Trajectory (reprinted with permission of the author from Ballentine, 2013).

https://csupalliativecare.org/wp-content/uploads/Five-Trajectories-eBook-02.21.2018.pdf



https://www.interiorhealth.ca/YourCare/PalliativeCare/PublishingImages/whatispalliative-lg.jpg

Timeframes in the dying process



REVIEW OF THE LIVERPOOL CARE PATHWAY REVIEW

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/212450/Liverpool_Care_Pathway.pdf

Masa Akhir Kehidupan

People are ‘approaching the end of life’

if they are likely to die within the next 12 months.

Saatnya menjelang ajal

People “at the end of life”

people who are imminently dying and might be in the last few hours or days of life.

https://www.dyingmatters.org/sites/default/files/user/10Questions.pdf

End-of-life care (or EoLC)

refers to health care for a person with **a terminal condition** that has become **a**dvanced, **p**rogressive, and/or **i**ncurable.

https://en.wikipedia.org/wiki/End-of-life_care


ADVANCED
PROGRESSIVE
INCURABLE


Bear in mind that even doctors with long experience tend to over-estimate prognosis.
https://static.scientificamerican.com

Ethical Principles

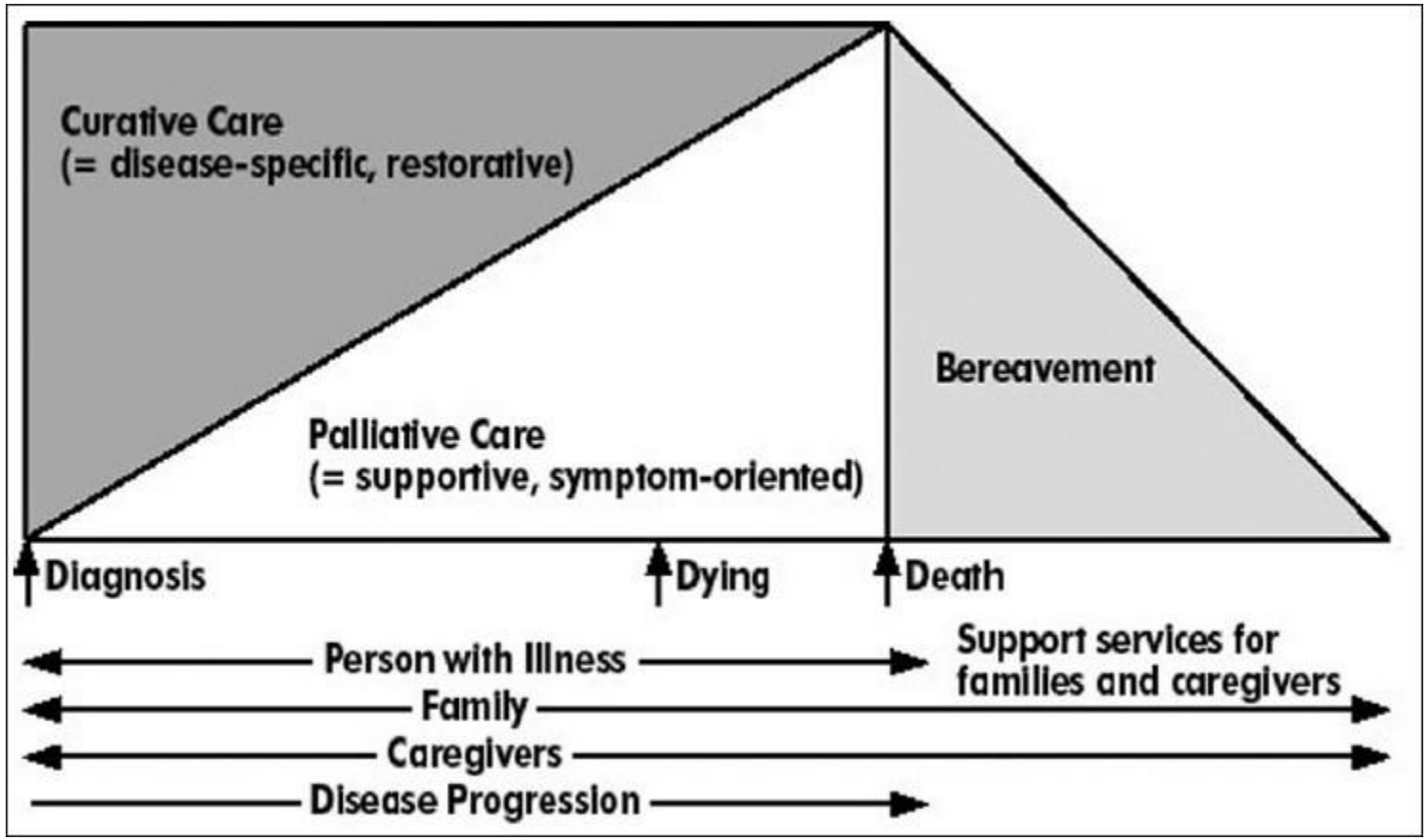
- **Autonomy:**
  Making one's own decision
- **Beneficence:**
  Intending to do good
- **Nonmaleficence:**
  Intending to do no harm
- **Justice:**
  Providing equal access

- Dignity - the patient and the persons treating the patient have the right to dignity
- Truthfulness and honesty - the concept of informed consent and truth telling

All these together constitute the six values of medical ethics.

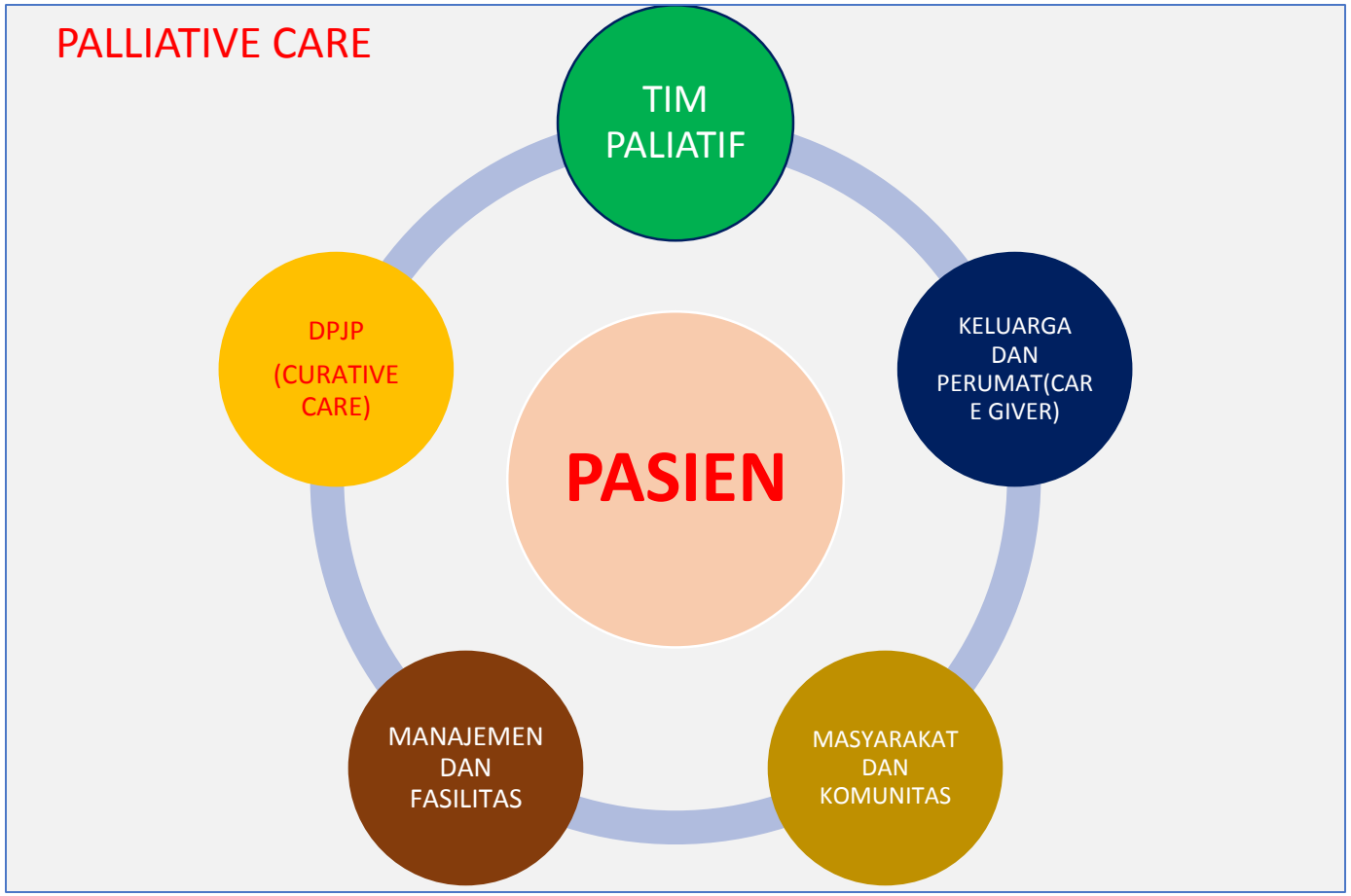
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2902121/

MODEL PERAWATAN PALIATIF



http://www.jpalliativecare.com/articles/2010/16/3/images/IndianJPalliatCare_2010_16_3_107_73639_f1.jpg

INTEGRASI PERAWATAN PALIATIF



KERJASAMA TIM

TIM PERAWATAN PALIATIF RUMAH SAKIT

- Dokter
- Perawat
- Fisioterapis
- Rohaniawan
- Pekerja sosial
- Farmasis
- …

Multidisipliner
Kolaborasi
Koordinatif

Seven principles of the Palliative Care Program:

1. People with a life-threatening illness and their carers and families have information about options for their future care and are actively involved in those decisions in the way that they wish
2. Carers of people with a life-threatening illness are supported by health and community care providers
3. People with a life-threatening illness and their carers and families have care that is underpinned by the palliative approach

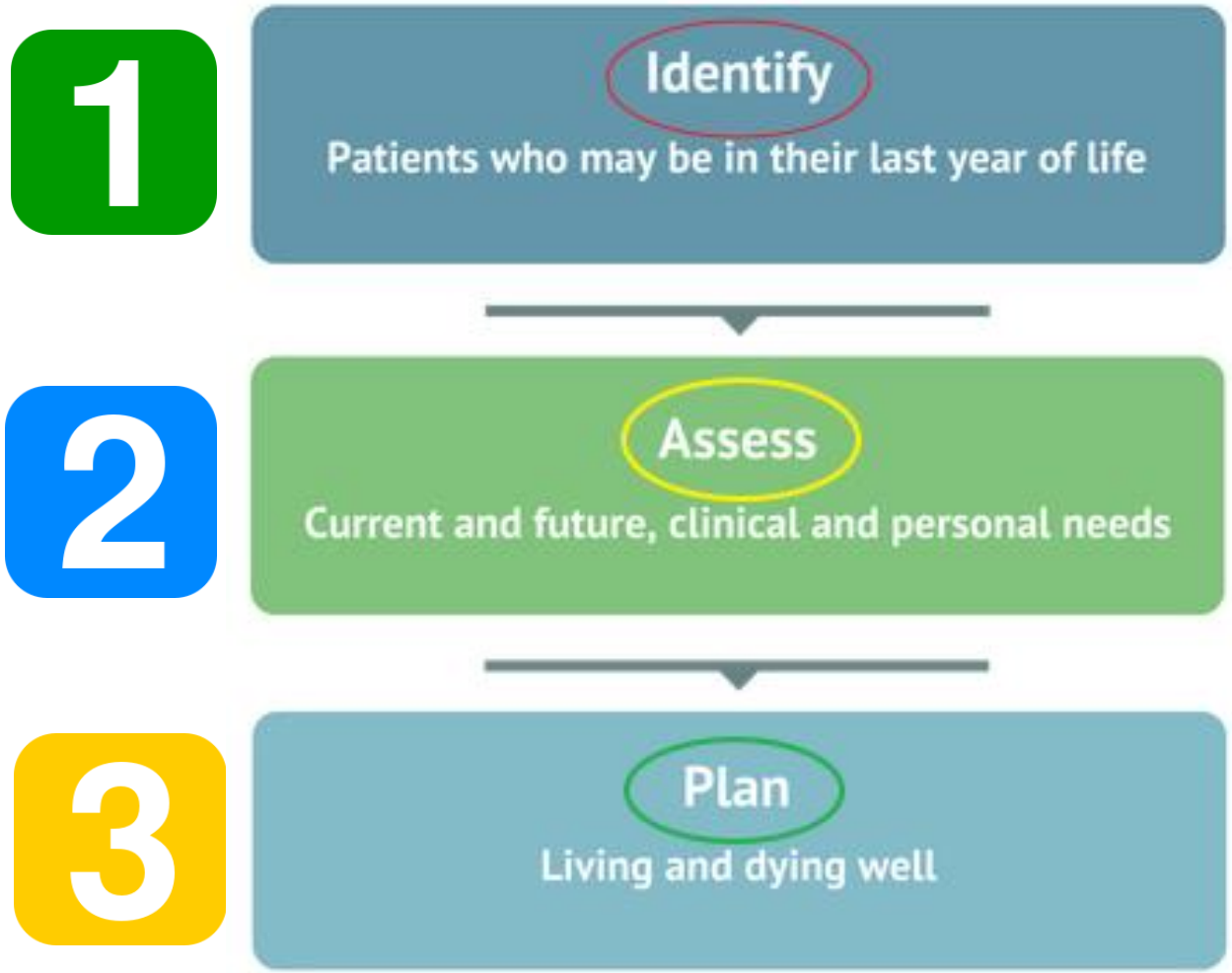
Source:
Stroke care strategy for Victoria
https://www2.health.vic.gov.au/Api/downloadmedia/%7B012C7C05-3760-49A2-A19D-391DA710D5A7%7D

Seven principles of the Palliative Care Program:

4. People with a life-threatening illness and their carers and families have access to specialist palliative care services when required
5. People with a life-threatening illness and their carers and families have treatment and care that is **coordinated** and **integrated** across all settings
6. People with a life-threatening illness and their carers and families have access to quality services and skilled staff to meet their needs
7. People with a life-threatening illness and their carers and families are supported by their communities.

Source:
Stroke care strategy for Victoria
https://www2.health.vic.gov.au/Api/downloadmedia/%7B012C7C05-3760-49A2-A19D-391DA710D5A7%7D

PROVIDING A PALLIATIVE APPROACH TO CARE



https://library.nshealth.ca/PalliativeCare

Step 1: Identify

Identify if the patient would benefit from palliative care earlier in their illness trajectory

Three **triggers** that suggest that patients could benefit from a palliative care approach:

1. **The Surprise Question:** 'Would you be surprised if the patient were to die in the next year?'

2. **General indicators of decline:** deterioration, advanced disease, decreased response to treatment, choice for no further disease modifying treatment.

3. **Specific clinical indicators** related to certain conditions.

Tool

THE UNIVERSITY of EDINBURGH

Supportive and Palliative Care Indicators Tool (SPICT-4ALL™)

The SPICT™ helps us to look for people who are less well with one or more health problems. These people need more help and care now, and a plan for care in the future. Ask these questions:

Does this person have signs of poor or worsening health?

- Unplanned (emergency) admission(s) to hospital.
- General health is poor or getting worse; the person never quite recovers from being more unwell. (This can mean the person is less able to manage and often stays in bed or in a chair for more than half the day)
- Needs help from others for care due to increasing physical and/ or mental health problems.
- The person's carer needs more help and support.
- Has lost a noticeable amount of weight over the last few months; or stays underweight.
- Has troublesome symptoms most of the time despite good treatment of their health problems.
- The person (or family) asks for palliative care; chooses to reduce, stop or not have treatment; or wishes to focus on quality of life.

Does this person have any of these health problems?

Cancer

Less able to manage usual activities and getting worse.

Not well enough for cancer treatment or treatment is to help with symptoms.

Dementia/ frailty

Unable to dress, walk or eat without help.

Eating and drinking less; difficulty with swallowing.

Has lost control of bladder and bowel.

Not able to communicate by speaking; not responding much to other people.

Frequent falls; fractured hip.

Frequent infections; pneumonia.

Nervous system problems

(eg Parkinson's, MS, stroke, motor neurone disease)

Physical and mental health are getting worse.

More problems with speaking and communicating; swallowing is getting worse.

Chest infections or pneumonia; breathing problems.

Severe stroke with loss of movement and ongoing disability.

Heart or circulation problems

Heart failure or has bad attacks of chest pain. Short of breath when resting, moving or walking a few steps.

Very poor circulation in the legs; surgery is not possible.

Lung problems

Unwell with long term lung problems. Short of breath when resting, moving or walking a few steps even when the chest is at its best.

Needs to use oxygen for most of the day and night.

Has needed treatment with a breathing machine in the hospital.

Kidney problems

Kidneys are failing and general health is getting poorer.

Stopping kidney dialysis or choosing supportive care instead of starting dialysis.

Liver problems

Worsening liver problems in the past year with complications like:

- fluid building up in the belly
- being confused at times
- kidneys not working well
- infections
- bleeding from the gullet

A liver transplant is not possible.

Other conditions

People who are less well and may die from other health problems or complications. There is no treatment available or it will not work well.

What we can do to help this person and their family.

- Start talking with the person and their family about why making plans for care is important.
- Ask for help and advice from a nurse, doctor or other professional who can assess the person and their family and help plan care.
- We can look at the person's medicines and other treatments to make sure we are giving them the best care or get advice from a specialist if problems are complicated or hard to manage.
- We need to plan early if the person might not be able to decide things in the future.
- We make a record of the care plan and share it with people who need to see it.

Please register on the SPICT website (www.spict.org.uk) for information and updates.

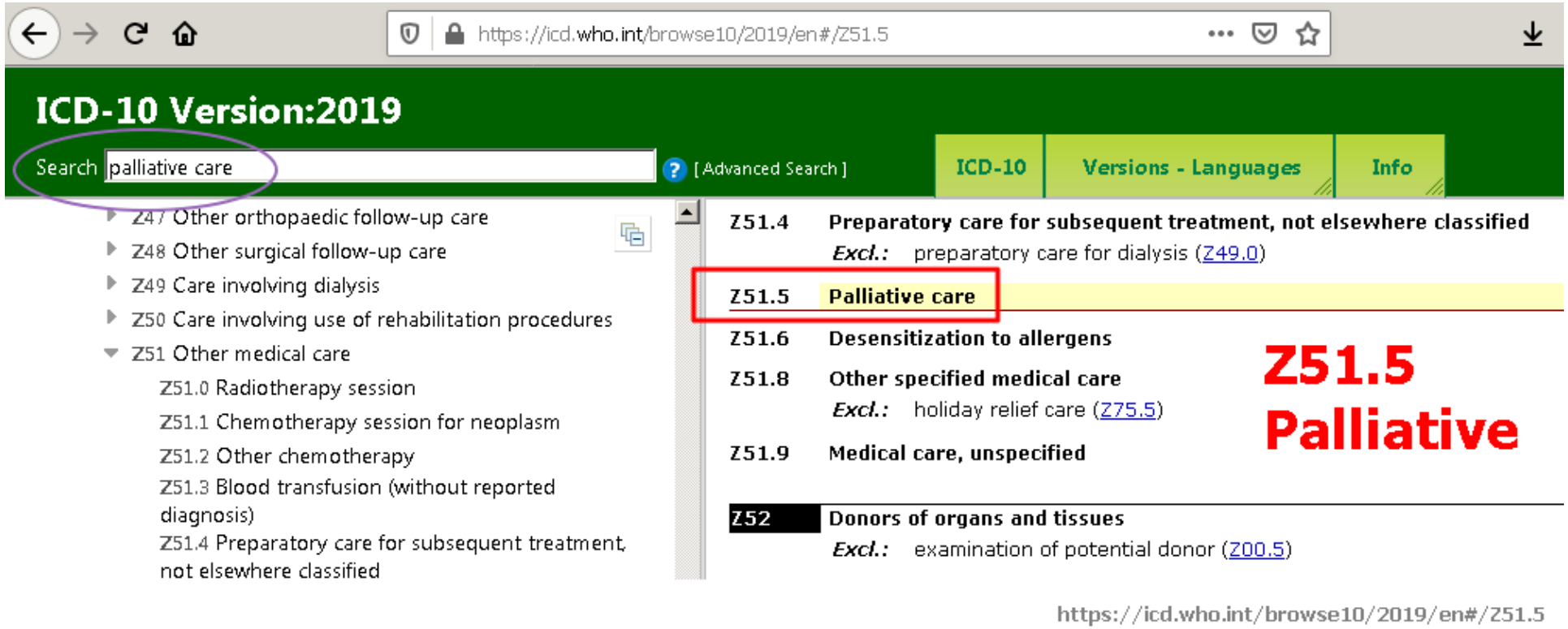
SPICT-4ALL™, June 2017

https://www.spict.org.uk/

NATIONAL INSTITUTES OF HEALTH STROKE SCALE (NIHSS)

Score	Stroke Severity
0	No stroke symptoms
1-4	Minor stroke
5-15	Moderate stroke
16-20	Moderate to severe stroke
21-42	Severe stroke

ICD-10 Version:2019



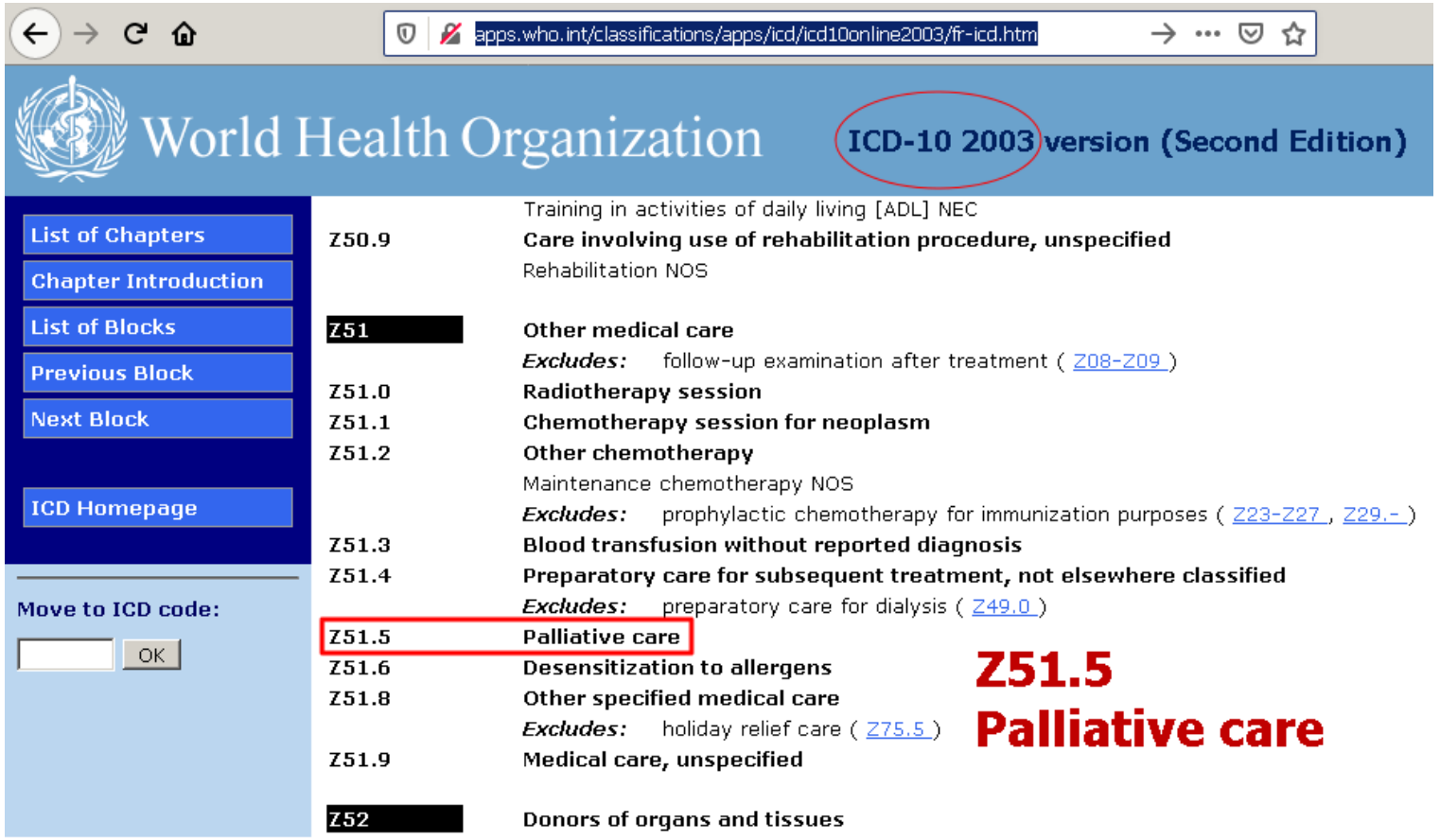
https://icd.who.int/browse10/2019/en#/Z51.5

ICD-10 2003 version (Second Edition)

ICD-10 2003 version (Second Edition)

Z51.5 = Palliative care

http://apps.who.int/classifications/apps/icd/icd10online2003/fr-icd.htm



Contoh:

- **Nontraumatic intracerebral hemorrhage, unspecified** I61.9
- Hemiplegia, unspecified G81.9
- Hypertension grade 2 I10
- Sepsis due to Staphylococcus aureus A41.0
- *Paliative Care* Z51.5 ←

SOAP

Dx: Palliative Care (Z51.5)

S (subyektif):

- Kadang meracau, tidak tenang
- Mual -, muntah -, kejang -, nyeri -
- Tidak BAB 7 hari

O (obyektif):

- Kesadaran menurun (GCS: E3M3V1 afasia)
- Tampak agak sesak
- Total bed bound
- PPS 30%

A (asesmen):

- Delirium (Konfusio)
- Konstipasi
- Palliative care on end of life stage.

P (planning):

- Haloperidol 5 mg iv bolus / 24 jam, Bisacodyl 5 mg / po / 24 jam extra
- Pengawasan respon dan efek samping obat (EPS)
- Antibiotik, hidrasi dan nutrisi diteruskan.
- Usaha matras decubitus
- *Family meeting* besok pagi
- Support mental pasien dan keluarga

Step 2: Assess

Assess the person's current and future needs and preferences across all domains of care.

Screening Tools

- **Palliative Performance Scale** (PPSv2)
- **Edmonton Symptom Assessment System** (ESAS-r)

https://www.ontariopalliativecarenetwork.ca/en/node/31896

A Circle Of Care
Victoria Hospice
SOCIETY

Palliative Performance Scale (PPSv2)

version 2

PPS Level	Ambulation	Activity & Evidence of Disease	Self-Care	Intake	Conscious Level
100%	Full	Normal activity & work No evidence of disease	Full	Normal	Full
90%	Full	Normal activity & work Some evidence of disease	Full	Normal	Full
80%	Full	Normal activity *with* Effort Some evidence of disease	Full	Normal or reduced	Full
70%	Reduced	Unable Normal Job/Work Significant disease	Full	Normal or reduced	Full
60%	Reduced	Unable hobby/house work Significant disease	Occasional assistance necessary	Normal or reduced	Full or Confusion
50%	Mainly Sit/Lie	Unable to do any work Extensive disease	Considerable assistance required	Normal or reduced	Full or Confusion
40%	Mainly in Bed	Unable to do most activity Extensive disease	Mainly assistance	Normal or reduced	Full or Drowsy +/- Confusion
30%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Normal or reduced	Full or Drowsy +/- Confusion
20%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Minimal to sips	Full or Drowsy +/- Confusion
10%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Mouth care only	Drowsy or Coma +/- Confusion
0%	Death	-	-	-	-

Stable
70 – 100 %

Transitional
40 – 60%

End-of-Life
0 -30 %

www.victoriahospice.org/sites/default/files/pps_english.pdf

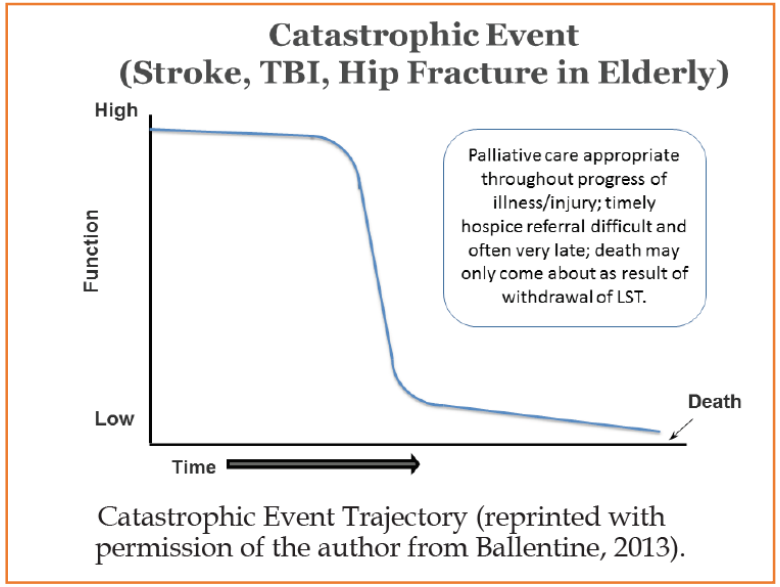
Edmonton Symptom Assessment System:
(revised version) (ESAS-R)

Please circle the number that best describes how you feel NOW:

PAIN	No Pain	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Pain
TIREDNESS	No Tiredness *(Tiredness = lack of energy)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Tiredness
DROWSINESS	No Drowsiness *(Drowsiness = feeling sleepy)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Drowsiness
NAUSEA	No Nausea	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Nausea
LACK OF APPETITE	No Lack of Appetite	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Lack of Appetite
SHORTNESS OF BREATH	No Shortness of Breath	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Shortness of Breath
DEPRESSION	No Depression *(Depression = feeling sad)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Depression
ANXIETY	No Anxiety *(Anxiety = feeling nervous)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Anxiety
WELLBEING	Best Wellbeing *(Wellbeing = how you feel overall)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Wellbeing
OTHER PROBLEM	No _____ Other Problem *(for example constipation)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible _____

11 SYMPTOMS

1. Pain
2. Anorexia
3. Nausea and vomiting
4. Constipation
5. Diarrhoea
6. Dyspnea
7. Fatigue
8. Delirium
9. Depression
10. Anxiety
11. Respiratory tract secretions

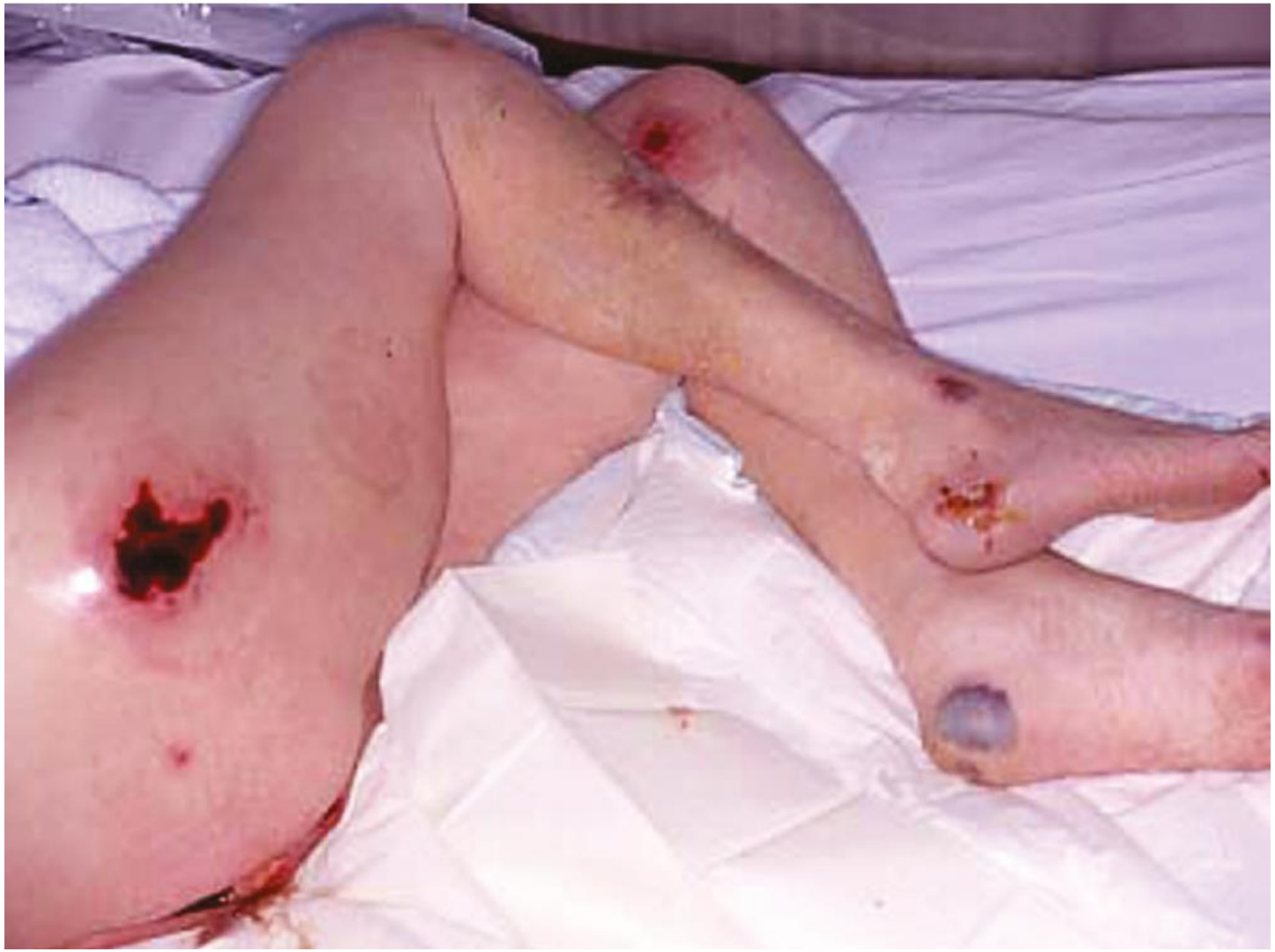


Catastrophic Event Trajectory (reprinted with permission of the author from Ballentine, 2013).

Fatigue	Pain	Lack of energy
Weakness	Appetite loss	Nervousness
Weight loss	Dry mouth	Depressed mood
Constipation	Worrying	Insomnia
Dyspnoea	Nausea	Anxiety
Irritability	Bloating	Cough
Cognitive symptoms	Early satiety	Taste changes
Sore mouth/stomatitis	Vomiting	Drowsiness
Oedema	Urinary symptoms	Dizziness
Dysphagia	Confusion	Bleeding
Neurological symptoms	Hoarseness	Dyspepsia
Skin symptoms	Diarrhoea	Pruritus
Hiccup		

Oxford Textbook of Palliative Medicine

Edited by Nathan I. Cherny Marie T. Fallon Stein Kaasa Russell K. Portenoy David C. Currow



ULKUS DEKUBITUS

Essential Drugs for Palliative Care

Acetaminophen/paracetamol	Amitriptyline	Atropine
Bisacodyl	Carbamazepine	Carbocisteine
Chlorpromazine	Citalopram	Clonazepam
Codeine	Desipramine	Dexamethasone
Dextromethorpan	Diazepam	Diclofenac
Dimenhydrinate	Diphenhydramine	Docusate
Fentanyl transdermal patch	Gabapentin	Glycopyrronium/glycopyrrolate
Haloperidol	Hyoscine butyl bromide	Hyoscine hydrobromide
Ibuprofen	Imipramine	Levomepromazine (Methotrimeprazine)
Loperamide	Lorazepam	Megestrol Acetate
Methadone	Metoclopramide	Midazolam
Morphine	Naproxen	Octreotide
Olanzapine	Ondansetron	Oxycodone
Phenytoin	Phenobarbital	Prochlorperazine
Risperidone	Senokot	Tramadol
Tranexamic Acid	Trazodone	

http://www.inctr.org/fileadmin/user_upload/inctr-admin/Media/Palliative_Care_Complete.pdf

Central post-stroke pain (CPSP)

- amitriptyline
- gabapentin
- ➢ opioids is not effective

Hemiplegic shoulder pain (HSP)

- intra-articular steroid injections

Goals of palliative care of stroke

- *Manage stroke symptoms through medicines and other treatments*
- *Counsel patient and his family on what to expect from disease and treatment*
- *Support the patient for the best quality of life*
- *Improve of quality of life for both patient and his family*

Family Meeting

INFORMATION

BREAKING BAD NEWS

FAMILY SUPPORT

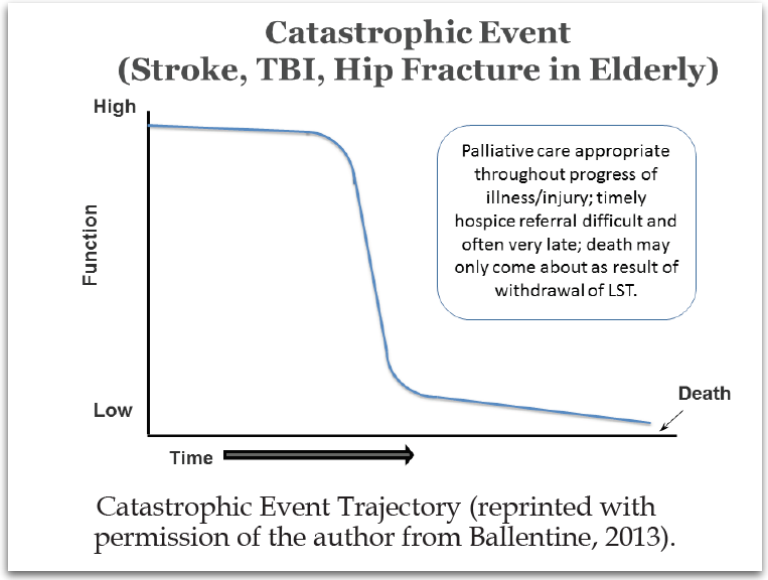
ADVANCED CARE PLANNING

ask

- VALUES
- WISHES
- BELIEFS
- PREFERENCES
- GOALS

BREAKING BAD NEWS

- Persiapkan dan Rencanakan
- Cari Tahu Apa yang Pasien dan Keluarga Tahu dan Ingin tahu
- Dukungan Emosi (Support Mental Pasien dan Keluarga)
- Membuat Rekomendasi
- Resolusi konflik



Catastrophic Event Trajectory (reprinted with permission of the author from Ballentine, 2013).

➢ prognostic uncertainty

periodically revisit discussions

individualized estimate

education about the nature of the stroke, stroke management, and outcome expectations

Source:
Palliative and End-of-Life Care in Stroke
A Statement for Healthcare Professionals From the American Heart Association/American Stroke Association
Holloway et al
https://www.ahajournals.org/doi/10.1161/STR.0000000000000015

DNR — Do-not-resuscitate

DNI — Do-not-intubate

making early DNR decisions or other limitations in treatment before fully understanding the prognosis

All people admitted to hospital with Acute stroke should receive:

- Swallow screen
  modification of diet or institution of NG feeding as appropriate within 48 hours
- Hydration Status: Maintain euvolemia.
- Assessment of continence
- Evaluation of pressure risk
- Early mobilisation where appropriate
- Occupational therapy and seating assessment
- Multidisciplinary assessment and discussion
- Assessment of mood
- Information meeting with relatives and patient

Source:
https://www.hse.ie/eng/services/publications/clinical-strategy-and-programmes/stroke-unit-management-care-bundle.pdf

SPIRITUAL CARE

Asking their patients about possible spiritual or religious beliefs and to offer referral to a chaplain or spiritual care provider

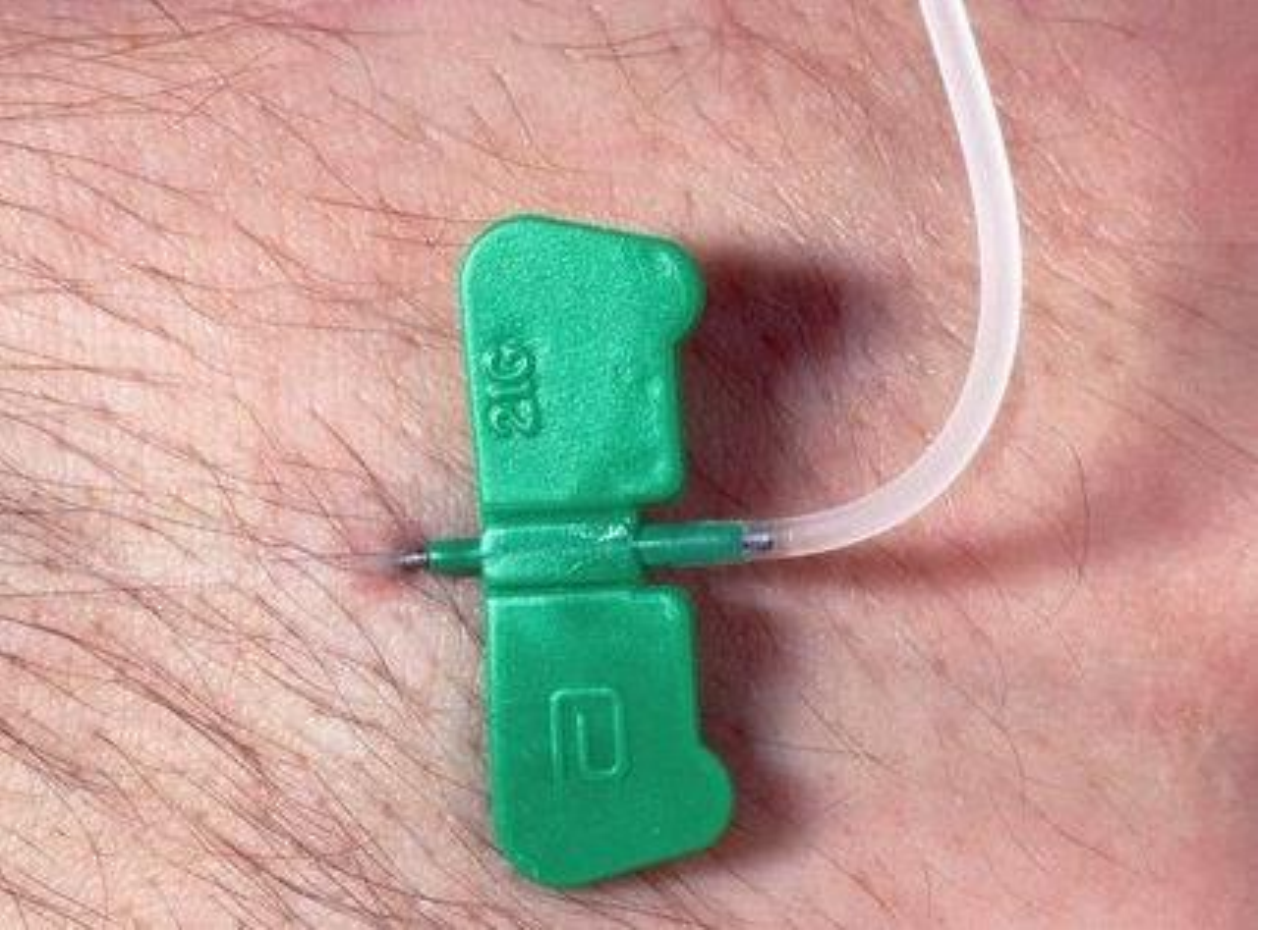
Every patient record should demonstrate a record of the patient's faith tradition (religious affiliation or belief system) or its absence.

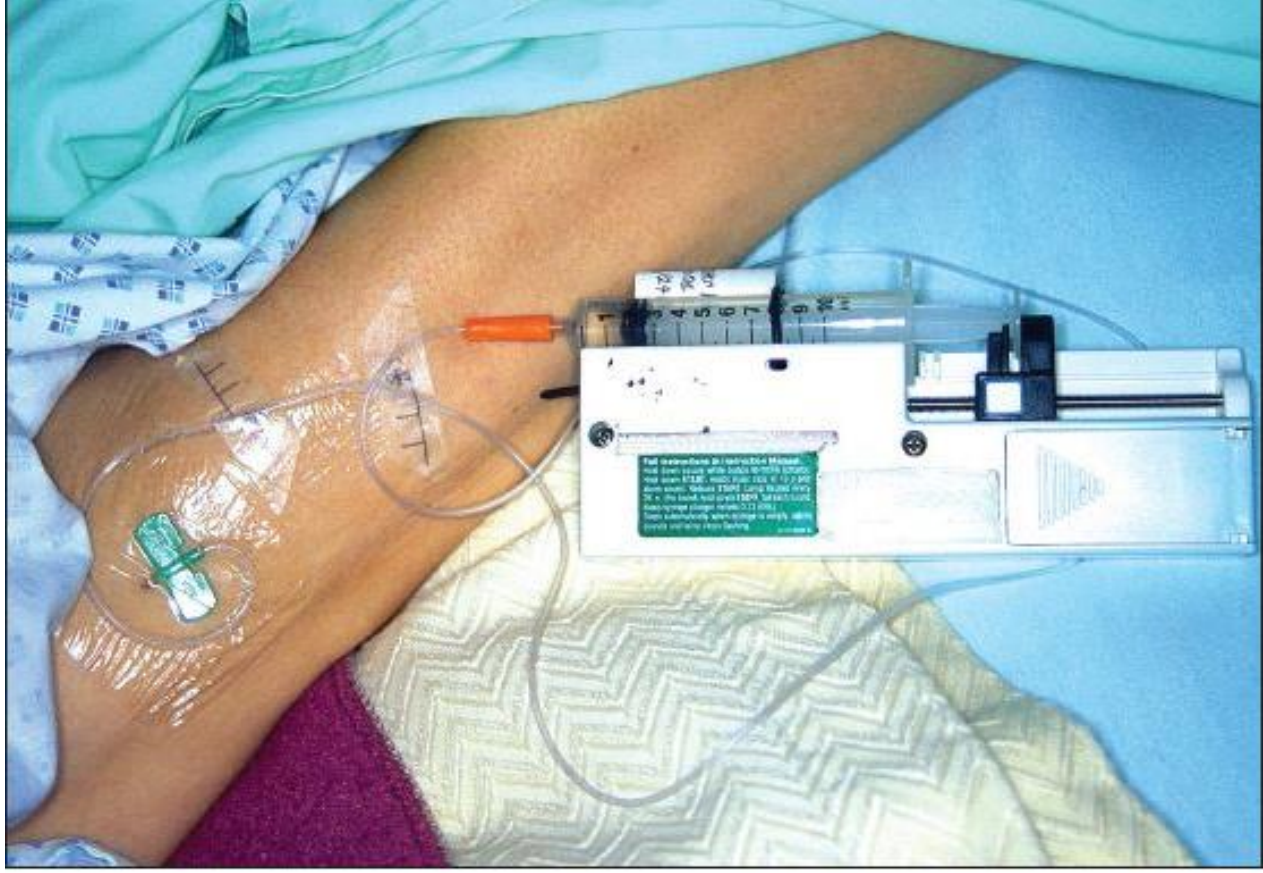
https://www.nwcscnsenate.nhs.uk/files/4914/0742/3855/Spirituality_Guidelines_-June_2014_FINAL.pdf

MENAHAN DAN MENGHENTIKAN TERAPI MEDIK
(TO WITHHOLD AND WITHDRAW = CURING VERSUS CARING)

Sesuai prinsip perawatan paliatif, tujuan terapi pada pasien stadium terminal adalah untuk mencapai kondisi nyaman dan meninggal secara bermartabat.

Sehingga terapi yang diberikan bertujuan untuk memperpanjang proses kematian harus dihentikan dan terapi yang tidak sesuai dengan tujuan di atas tidak mungkin diberikan.



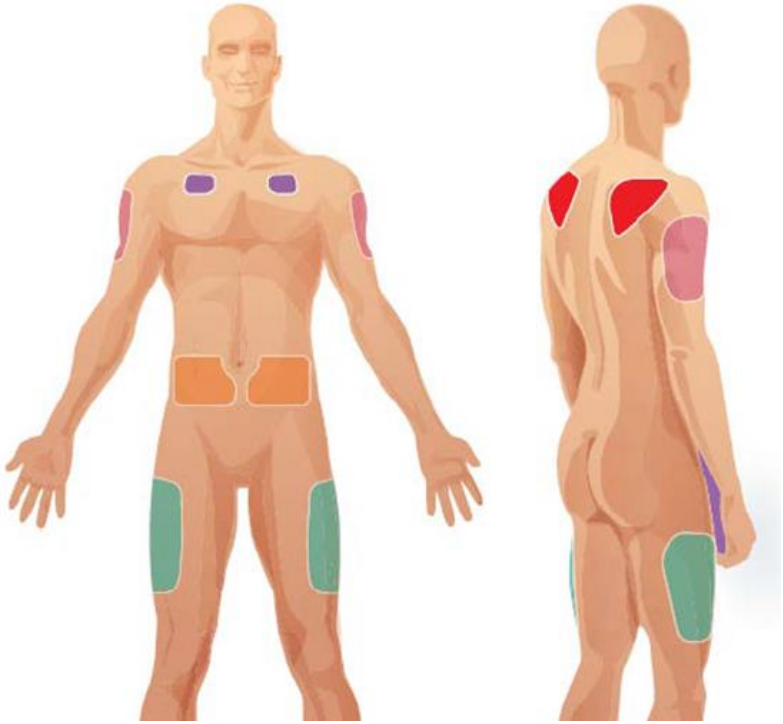


https://www.prescriber.co.uk/article/opioid-use-in-palliative-care-new-developments-

Infus dan Injeksi Subkutan

In the palliative care setting the IV route is rarely used.

SUBCUTANEOUS INSERTION SITES



Hypodermoclysis (HDC)

Refers to the subcutaneous administration of fluid and electrolytes for the treatment and prevention of mild to moderate dehydration.

For all other uses, the term subcutaneous therapy should be used.

Upper Back (Scapula)
Use when other sites unsuitable or client confused/restless

Subclavicular Area
Avoid when client:

- has lung disease
- is active (risk of pneumothorax)

Upper Arms
Avoid if possible for HDC

Abdomen
Avoid in presence of tense abdominal pressure

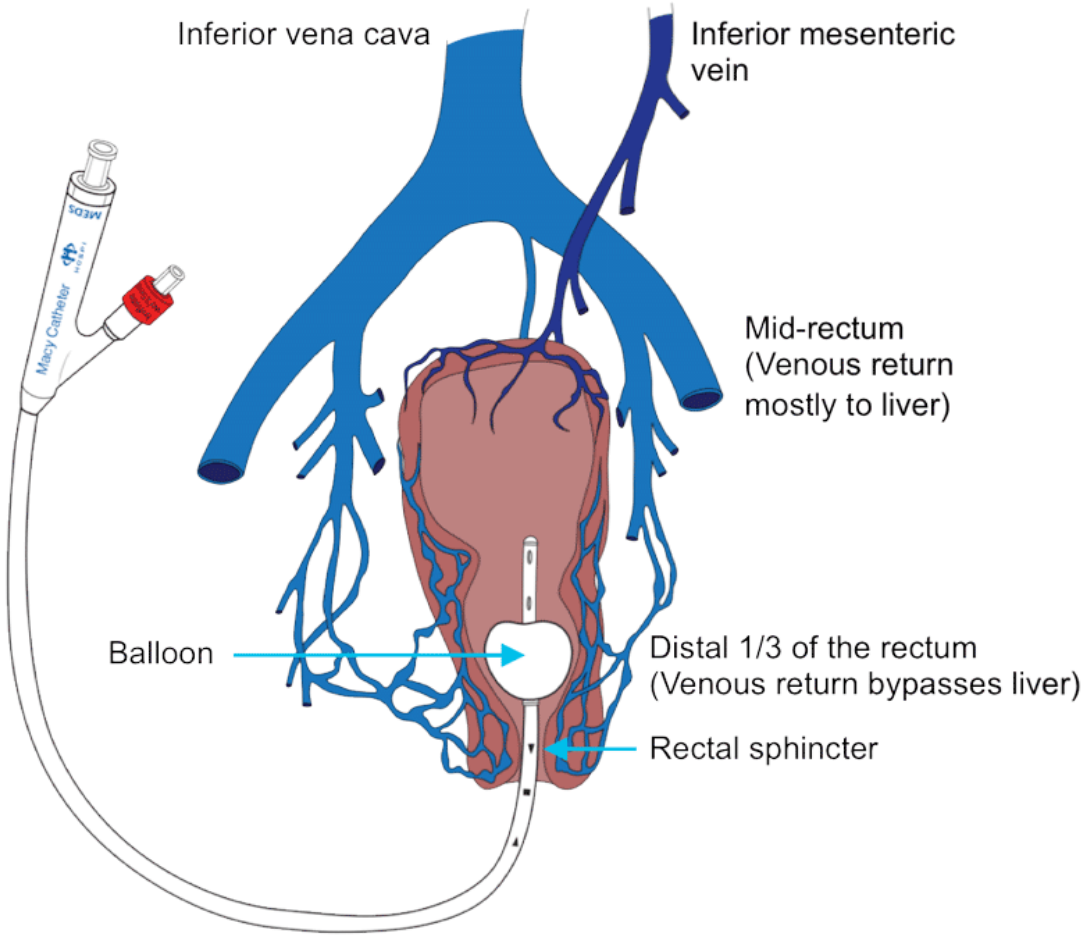
Thighs
Best location for HDC

Medicine	Morphine	Oxycodone	Fentanyl	Methadone	Metoclopramide	Cyclizine	Haloperidol	Methotrimeprazine	Midazolam	Clonazepam	Hyoscine butylromide	Dexamethasone
Morphine	–	NA	NA	NA	Y	Y	Y/SI	Y	Y	Y	Y/?	Y
Oxycodone	NA	–	NA	NA	Y	SI	Y	Y	Y	Y	Y	Y
Fentanyl	NA	NA	–	NA	Y	SI	Y	Y	Y	?	Y	?
Methadone	NA	NA	NA	–	Y	?	Y	Y	Y	Y	?	Y
Metoclopramide	Y	Y	Y	Y	–	Y	Y	Y	Y	Y	Y	Y
Cyclizine†	Y	SI	SI	?	Y	–	Y	Y	SI	SI	SI	SI
Haloperidol	Y/SI	Y	Y	Y	Y	Y	–	Y	Y	Y	Y	SI
Levomepromazine (Methotrimeprazine)	Y	Y	Y	Y	Y	Y	Y	–	Y	Y	Y	SI
Midazolam	Y	Y	Y	Y	Y	SI	Y	Y	–	Y	Y	SI
Clonazepam	Y	Y	?	Y	Y	SI	Y	Y	Y	–	Y	Y
Hyoscine butylbromide (Buscopan)	Y/?	Y	Y	?	Y	SI	Y	Y	Y	Y	–	Y
Dexamethasone‡	Y	Y	?	Y	Y	SI	SI	SI	SI	Y	Y	–

When and how to use a syringe driver in palliative care
https://bpac.org.nz/BPJ/2012/November/syringedrivers.aspx

The **Macy Catheter** is designed to facilitate discreet and painless rectal administration of fluids and medications.

https://www.macycatheter.com/hospice-palliative-care/



Why Rectal Delivery Works

- ✓ Mucosa is highly vascularized
- ✓ High % absorptive cells
- ✓ Suspensions or solutions are generally absorbed more quickly than suppositories
- ✓ Increased bioavailability (distal 1/3 of rectum venous return bypasses liver)

https://www.macycatheter.com/hospice-palliative-care/

Rectal route

Palliative Care Per Rectum

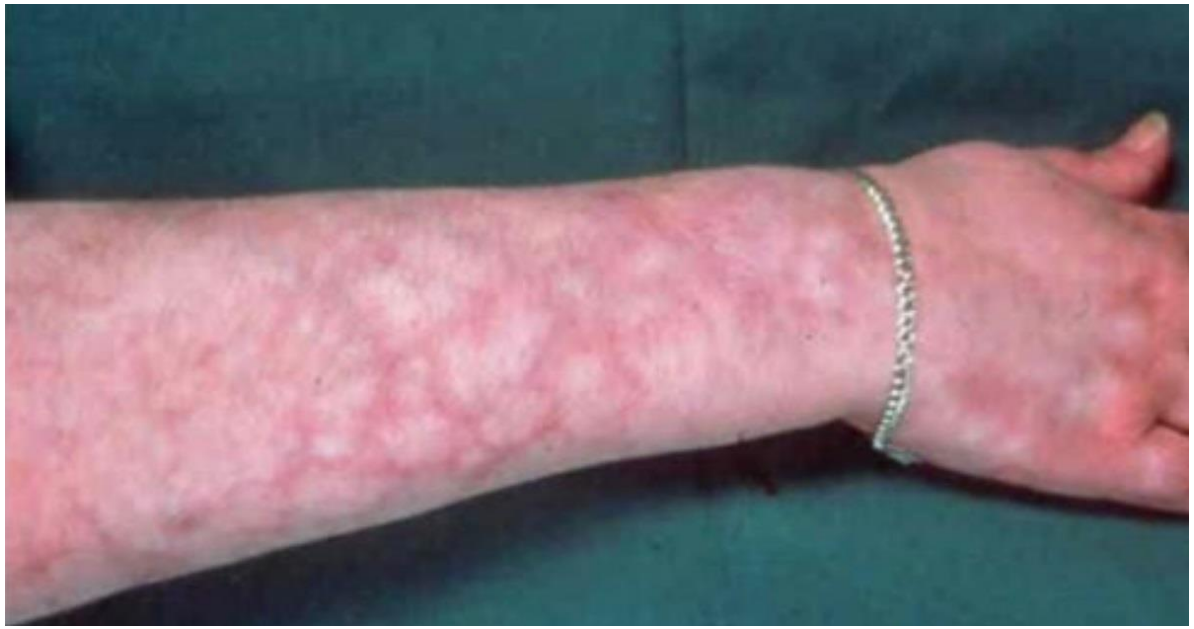
Opioid Analgesics	NSAID's	Laxatives	Anti-Epileptics
Morphine*	Acetaminophen*	Glycerin*	Phenobarbital
Hydromorphone*	Diclofenac	Sodium phosphates*	Pentobarbital
Methadone	Indomethacin*	Mineral oil*	Phenytoin
Oxycodone	Ibuprofen	Bisacodyl*	Carbamazepine
Codeine	Naproxen	Docusate*	Valproic Acid
Tramadol	Aspirin		Lamotigrine
Corticosteroids	**Anxiolytics**	**Anti-Emetics**	
Hydrocortisone	Diazepam*	Prochlorperazine*	
Prednisolone	Lorazepam	Promethazine*	
Dexamethasone	Midazolam	Chlorpromazine	
	Clonazepam	Metoclopramide	
		Ondansetron	

Palliative Care Per Rectum
https://www.mypcnow.org/fast-fact/palliative-care-per-rectum/

When Death Nears:

- Sleeping
- Loss of Interest in Food and Fluids
- Coolness
- Changes in Skin Color
- Rattling Sounds in the Lungs and Throat
- Bladder and Bowel Changes
- Disorientation and Restlessness
- Surge of Energy
- Breathing Pattern Changes

MOTTLED SKIN



Mottled skin occurs before death and is a strong indicator that death is imminent.

WITHHOLD & WITHDRAW

Tidak memberikan dan Menghentikan

Obat-obatan, Tindakan dan Pemeriksaan mungkin perlu dipertimbangan untuk tidak diberikan, dan yang sudah diberikan tidak diberikan lagi.

Reviewing Regular Medication.

The patient may have an altered level of consciousness or significantly reduced oral intake and therefore struggle to swallow medication. Review current medication and discontinue any medication that is no longer of benefit to the patient. For example:

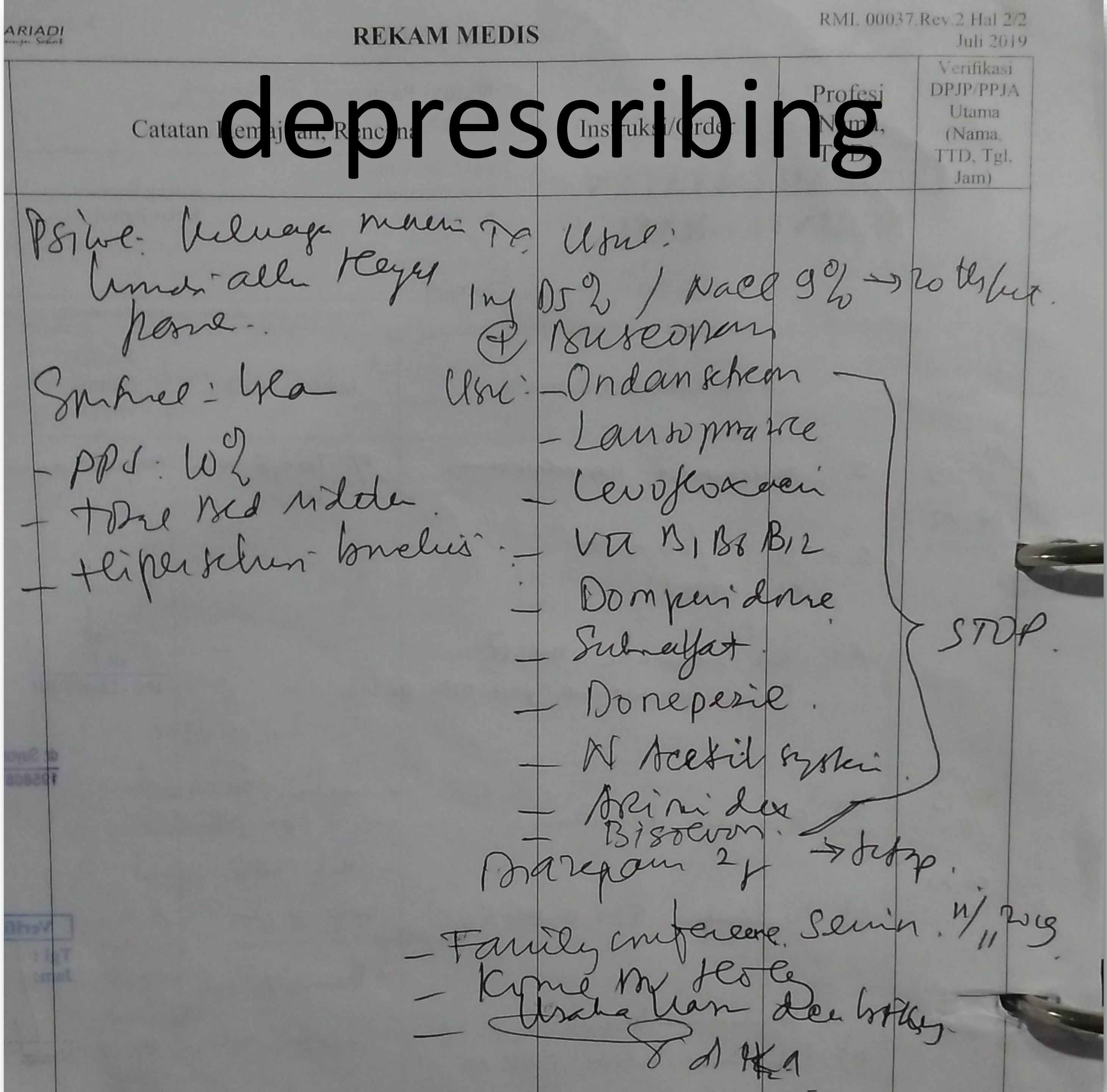
Anti-Hypertensives	Corticosteroids	Hypoglycaemics*
Antibiotics**	Diuretics**	Iron / Vitamin preparations
Anti-arrhythmics	Haematinics	Statins
Anti-coagulants	Hormone therapy	Steroids (long term)***

Stopping unnecessary medications

Decisions about which medications to stop should be made by balancing the likely prognosis from the palliative care diagnosis, with short, medium, and long-term risks associated with stopping medications to manage co-morbidities.

https://www.caresearch.com.au/caresearch/ProfessionalGroups/NursesHubHome/Clinical/MedicationManagement/PalliativeMedications/tabid/1554/Default.aspx

deprescribing



ARIADI

REKAM MEDIS

RML 00037.Rev.2 Hal 2/2
Juli 2019

Catatan Kemajuan, Rencana	Instruksi/Order	Profesi Nama, TTD	Verifikasi DPJP/PPJA Utama (Nama, TTD, Tgl, Jam)
Psikol: keluarga mau [illegible] [illegible] pasien. Spiritual: t/a - PPS: 10% - Total bed ridden - Hipersekresi bronkus.	Th/ Usul: Inj D5% / NaCl 0,9% → 20 tts/mnt. + Buscopan Usul: - Ondansetron - Lansoprazole - Levofloxacin - Vit B1 B6 B12 - Domperidone - Sukralfat - Donepezil - N Acetil sistein - Arimidex - Bisolvon } STOP. Diazepam 2 [illegible] → stop. - Family conference Senin 11/11 2019 - Konsul [illegible] - Usaha [illegible] [illegible] dr [illegible]		

Palliative sedation

In medicine, specifically in end-of-life care, palliative sedation (also known as terminal sedation, continuous deep sedation, **or sedation for intractable distress in the dying/of a dying patient)** is the palliative practice of relieving distress in a terminally ill person **in the last hours or days of a dying** patient's life,

Minimally effective amount of sedation necessary to relieve refractory symptoms

From Wikipedia

Symptom Management in Palliative Patients

Symptom	Drugs	Recommended dose
Restlessness	Midazolam 10 mg/2ml	2.5-5 mg PRN
	Haloperidol 5 mg/ml	1.5-3 mg QDS
	Levomepromazine 25 mg/ml	12.5-25 mg
Nausea and vomiting	Metoclopramide 10mg/2ml	10mg TDS
	Cyclizine 50mg/ml	50mg TDS
	Levomepromazine 25 mg/ml	12.5-25 mg
	Haloperidol 5 mg/ml	1.5-3 mg QDS
Respiratory tract secretions	Hyoscine butylbromide 20 mg/ml	20 mg QDS
	Hyoscine hydrobromide 400 mcg/ml	400 mcg
	Glycopyrronium 200 mcg/ml	200-400 mcg
Pain	Diamorphine 5 mg	2.5-5 mg
	Morphine 10 mg/ml	5-10 mg
	Oxycodone 10 mg/ml	2.5-5 mg
	Alfentanil 1 mg/2ml	300 mcg

Anticipatory Medicines

‘Just in Case’ medicines

- Pain
- Shortness of breath
- Sickness/Nausea
- Secretions in the throat
- Restlessness/agitation

Care planning and regular review

- Food and drinks

  Assisted hydration or nutrition: consider the benefits and risks and review plan regularly.
- Medication:

  stop any treatments not consistent with the agreed goals of care

  continue medications consistent with goals of care
- Make a clear record of any interventions that are not appropriate.
- Consider emotional, spiritual, religious, cultural, legal and family needs
- Bereavement: identify those at increased risk of complicated grief

https://www.palliativecareguidelines.scot.nhs.uk/guidelines/end-of-life-care/Care-in-the-Last-Days-of-Life.aspx

DEATH

Here are indications
that death has occurred:

- **No breathing for a prolonged period of time**
- **No heartbeat**
- **Eyes are fixed and slightly open, with enlarged pupils**
- **Jaw relaxed, with the mouth slightly open**


AMAN - LANCAR - SELAMAT
SAMPAI TUJUAN

GOOD DEATH

KHUSNUL KHATIMAH

Principles of a good death

1. · To know when death is coming, and to understand what can be expected
2. · To be able to retain control of what happens
3. · To be afforded dignity and privacy
4. · To have control over pain relief and other symptom control
5. · To have choice and control over where death occurs (at home or elsewhere)
6. · To have access to information and expertise of whatever kind is necessary
7. · To have access to any spiritual or emotional support required
8. · To have access to hospice care in any location, not only in hospital
9. · To have control over who is present and who shares the end
10. · To be able to issue advance directives which ensure wishes are respected
11. · To have time to say goodbye, and control over other aspects of timing
12. · To be able to leave when it is time to go, and not to have life prolonged pointlessly

PALLIATIVE CARE

COMMUNICATION IS

Providing good psychosocial care comes down to good communication skills, both verbal and non-verbal.

The seven Cs of primary palliative care

- Communication
- Coordination
- Control of symptoms
- Continuity of care
- Continued learning
- Carer support
- Care of the dying pathway

https://www.mja.com.au/journal/2010/193/2/palliative-care-beyond-cancer-australia

STANDAR NASIONAL AKREDITASI RUMAH SAKIT
(Edisi 1)

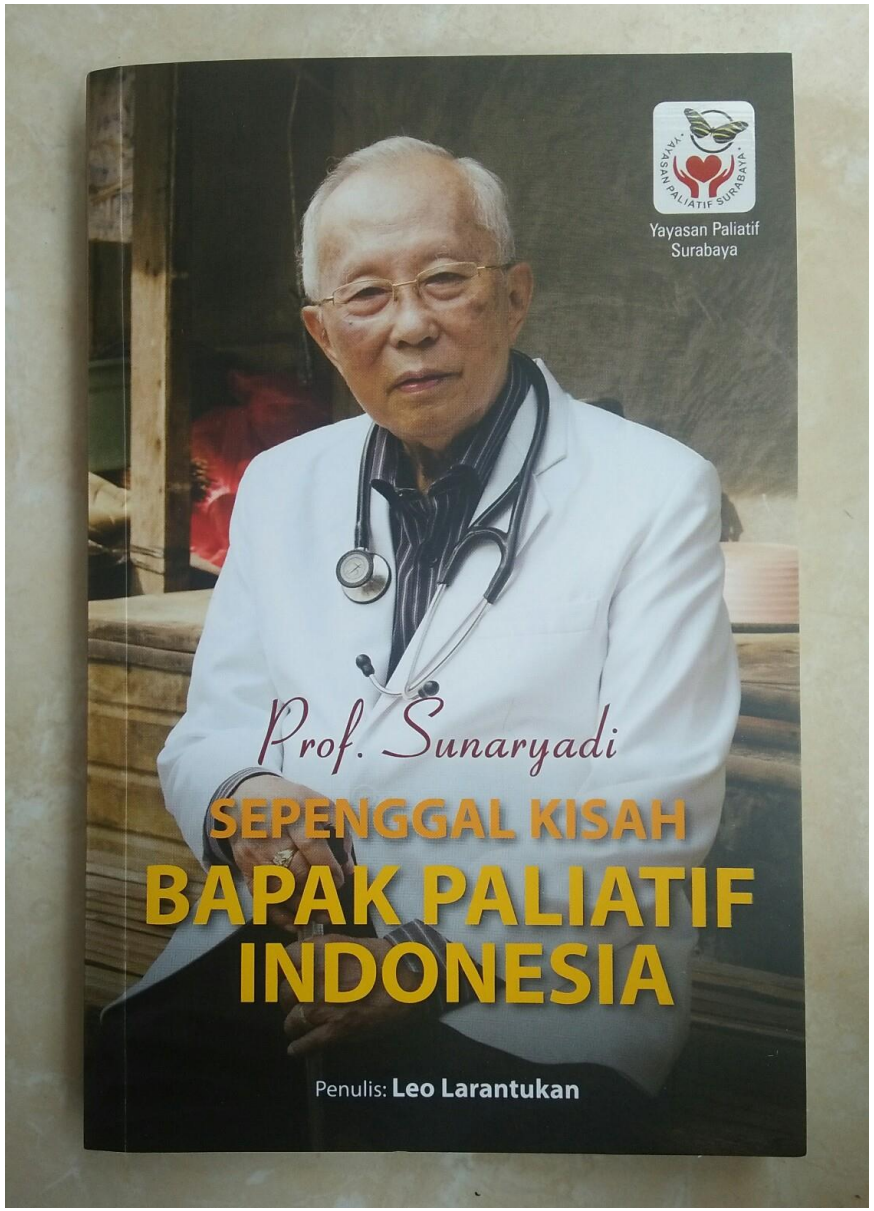
Rumah sakit menetapkan proses untuk mengelola
ASUHAN PASIEN DALAM TAHAP TERMINAL.

Proses ini meliputi

a) intervensi pelayanan pasien untuk mengatasi nyeri;
b) memberikan pengobatan sesuai dengan gejala dan mempertimbangkan keinginan pasien dan keluarga;
c) menyampaikan secara hati-hati soal sensitif seperti autopsi atau donasi organ;
d) menghormati nilai, agama, serta budaya pasien dan keluarga;
e) mengajak pasien dan keluarga dalam semua aspek asuhan;
f) memperhatikan keprihatinan psikologis, emosional, spiritual, serta budaya pasien dan keluarga.

http://www.pdpersi.co.id/kanalpersi/manajemen_mutu/data/snars_edisi1.pdf

TAMAN PALIATIF
RSUP DR KARIADI SEMARANG, 2019



Prof. Sunaryadi
BAPAK PALIATIF INDONESIA

Nama:
Prof. Raden Sunaryadi Tejawinata,
dr. SpTHT(K-Onk), FICS, FAAO, PGD, Pall.Med.(ECU)

Lahir:
Cirebon, 23 Agustus 1934

DEKLARASI PERDOPIN

(Perhimpunan Dokter Paliatif Indonesia)

Surabaya, 22 Februari 2014

APHC 2019 - 13th Asia Pacific Hospice Conference

Aug 01 - 04, 2019, Surabaya

BIMTEK PELAYANAN PERAWATAN PALIATIF DAN AKHIR KEHIDUPAN
RSUD TUGUREJO, SEMARANG. (13 FEBRUARI 2020)

SUGGESTED READING

RESOURCES TO SUPPORT YOUR CONTINUED LEARNING ABOUT PALLIATIVE CARE AND END OF LIFE CARE

- https://acclaimhealth.ca/programs/palliative-care-consultation/palliative-care-resources
- https://www.palliativecareguidelines.scot.nhs.uk/guidelines.aspx
- https://www.ontariopalliativecarenetwork.ca/en/node/31896
- http://www.mhpcn.net/palliative-care-toolbox
- https://library.nshealth.ca/PalliativeCare
- https://palliativecareindonesia.blogspot.com
- **Palliative and End-of-Life Care in Stroke**
  https://sites.google.com/view/palliativecareinstroke/home

Download materi:

http://bit.ly/2TPCsRN


THANK YOU
https://live.staticflickr.com/3776/10412968824_c1ee1d5348_b.jpg